




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/ca/52SHSMG01012020>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (855) 383-7248 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall <a href="#">deductible</a> ?                                | \$5,000/person or \$10,000/family for In- <a href="#">Network Providers</a> . \$10,000/person or \$20,000/family for Non- <a href="#">Network Providers</a> .        | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive Care</a> for In- <a href="#">Network Providers</a> . Vision for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| Are there other <a href="#">deductibles</a> for specific services?              | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$6,750/person or \$13,500/family for In- <a href="#">Network Providers</a> . \$13,500/person or \$27,000/family for Non- <a href="#">Network Providers</a> .        | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.   | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .  |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes, Prudent Buyer PPO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 383-7248 for a list of <a href="#">network providers</a> .        | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

|  |     |  |
|--|-----|--|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No. | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |
|--|-----|--|

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event  | Services You May Need   | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|---|---|--|---|---|
|   |   | In-Network Provider<br>(You will pay the least)  | Non-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic  | Primary care visit to treat an injury or illness  | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                 | -----none-----  |
|   | <a href="#">Specialist</a> visit  | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                 | -----none-----  |
|   | <a href="#">Preventive care</a> / <a href="#">screening</a> /<br>immunization                     | No charge  | 50% <a href="#">coinsurance</a>                 | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test  | <a href="#">Diagnostic test</a> (x-ray, blood work)   | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                 | -----none-----  |
|   | Imaging (CT/PET scans, MRIs)  | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                 | \$380 maximum benefit/admission for Non- <a href="#">Network Providers</a> .  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a><br>Select Drug List | Tier 1 - Typically Generic  | 35% <a href="#">coinsurance</a> up to \$500/prescription (retail) and 35% <a href="#">coinsurance</a> up to \$1,500/prescription (home delivery) | Not covered (retail and home delivery)          | Most home delivery is 90-day supply. *See Prescription Drug section of the <a href="#">plan</a> or policy document (e.g. evidence of coverage or certificate).                            |
|   | Tier 2 - Typically <a href="#">Preferred Brand</a> & Non- <a href="#">Preferred Generic</a> Drugs | 35% <a href="#">coinsurance</a> up to \$500/prescription (retail) and 35% <a href="#">coinsurance</a> up to \$1,500/prescription (home delivery) | Not covered (retail and home delivery)          |   |
|   | Tier 3 - Typically Non- <a href="#">Preferred Brand</a> and Generic drugs                         | 35% <a href="#">coinsurance</a> up to \$500/prescription (retail) and 35% <a href="#">coinsurance</a> up to \$1,500/prescription (home delivery) | Not covered (retail and home delivery)          |   |
|   | Tier 4 - Typically <a href="#">Preferred Specialty</a> (brand and generic)                        | 35% <a href="#">coinsurance</a> up to \$500/prescription (retail and home delivery)  | Not covered (retail and home delivery)          |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)  | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                 | \$380 maximum benefit/admission for Non- <a href="#">Network Providers</a> .  |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/52SHSMG01012020>.

| Common Medical Event  | Services You May Need                            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | In-Network Provider<br>(You will pay the least)  | Non-Network Provider<br>(You will pay the most)  |   |
|   | Physician/surgeon fees                           | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | -----none-----  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 45% <a href="#">coinsurance</a>  | Covered as In- <a href="#">Network</a>   | Copay waived if admitted. 45% <a href="#">coinsurance</a> for Emergency Room Physician Fee.   |
|   | <a href="#">Emergency medical transportation</a> | 45% <a href="#">coinsurance</a>  | Covered as In- <a href="#">Network</a>   | Non-emergency non- <a href="#">network</a> Ambulance Services are limited to \$50,000 per occurrence.   |
|   | <a href="#">Urgent care</a>                      | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | -----none-----  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | \$650 maximum benefit/day for Non- <a href="#">Network Providers</a> . 100 days/benefit period for Inpatient rehabilitation.  |
|   | Physician/surgeon fees                           | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | -----none-----  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit<br>45% <a href="#">coinsurance</a><br>Other Outpatient<br>45% <a href="#">coinsurance</a> | Office Visit<br>50% <a href="#">coinsurance</a><br>Other Outpatient<br>50% <a href="#">coinsurance</a> | Office Visit<br>-----none-----<br>Other Outpatient<br>-----none-----  |
|   | Inpatient services                               | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | \$650 maximum benefit/day for Non- <a href="#">Network Providers</a> . 45% <a href="#">coinsurance</a> for Inpatient Physician Fee In- <a href="#">Network Providers</a> . 50% <a href="#">coinsurance</a> for Inpatient Physician Fee Non- <a href="#">Network Providers</a> .   |
| If you are pregnant   | Office visits                                    | No charge  | 50% <a href="#">coinsurance</a>  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . 45% <a href="#">coinsurance</a> for Postnatal In- <a href="#">Network Providers</a> . In- <a href="#">Network</a> preventative prenatal and postnatal services are covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services        | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  |   |
|   | Childbirth/delivery facility services            | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  |   |
| If you need help recovering or  | <a href="#">Home health care</a>                 | 45% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | \$75 maximum benefit/visit for Non- <a href="#">Network Providers</a> . 100   |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/52SHSMG01012020>.

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                    |   | Limitations, Exceptions, & Other Important Information   |
|--|---|--|---|--|
|  |   | In-Network Provider<br>(You will pay the least)      | Non-Network Provider<br>(You will pay the most)   |  |
| health needs                           |   |  |   | visits/year for Home Health and Private Duty Nursing combined.   |
|  | <a href="#">Rehabilitation services</a>   | 45% <a href="#">coinsurance</a>                      | 50% <a href="#">coinsurance</a>   | *See Therapy Services section.   |
|  | <a href="#">Habilitation services</a>     | 45% <a href="#">coinsurance</a>                      | 50% <a href="#">coinsurance</a>   |  |
|  | <a href="#">Skilled nursing care</a>      | 45% <a href="#">coinsurance</a>                      | 50% <a href="#">coinsurance</a>   | \$150 maximum benefit/day for Non- <a href="#">Network Providers</a> . 100 days/benefit period for skilled nursing services. |
|  | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>                      | 50% <a href="#">coinsurance</a>   | *See <a href="#">Durable Medical Equipment</a> Section   |
|  | <a href="#">Hospice services</a>          | 0% <a href="#">coinsurance</a>                       | 50% <a href="#">coinsurance</a>   | -----none-----   |
| If your child needs dental or eye care | Children's eye exam                       | \$0/visit, <a href="#">deductible</a> does not apply | \$0 <a href="#">copayment</a> up to <a href="#">plan's</a> Maximum <a href="#">Allowed Amount</a> | *See Vision Services section   |
|  | Children's glasses                        | \$0/unit, <a href="#">deductible</a> does not apply  | \$0 <a href="#">copayment</a> up to <a href="#">plan's</a> Maximum <a href="#">Allowed Amount</a> |  |
|  | Children's dental check-up                | 0% <a href="#">coinsurance</a>                       | 0% <a href="#">coinsurance</a>  | *See Dental Services section   |

### Excluded Services & Other Covered Services:

|   |   |  |
|---|---|--|
| <b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b> |   |  |
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Long-term care</li> </ul>  | <ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Routine foot care unless medically necessary</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Weight loss programs</li> </ul> |

|  |   |  |
|--|---|--|
| <b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>  |   |  |
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Infertility treatment Limited to Medically Necessary iatrogenic fertility preservation services.</li> <li>• Routine eye care (Adult) 1 exam/benefit period.</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care 20 visits/year</li> <li>• Private-duty nursing 100 visits/year combined with Home Health</li> </ul> |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhc.ca.gov/>, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/52SHSMG01012020>.

contact Anthem at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhca.ca.gov/>

California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th St, Suite #500, Sacramento, CA 95814, (888) 466-2219, <https://www.dmhca.ca.gov/>

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/52SHSMG01012020>.

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby<br>(9 months of in-network pre-natal care and a hospital delivery)  |                 | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)   |                | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)  |                |
|--|-----------------|--|----------------|--|----------------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a>  | \$5,000         | ■ The <a href="#">plan's</a> overall <a href="#">deductible</a>  | \$5,000        | ■ The <a href="#">plan's</a> overall <a href="#">deductible</a>  | \$5,000        |
| ■ <a href="#">Specialist coinsurance</a>   | 45%             | ■ <a href="#">Specialist coinsurance</a>   | 45%            | ■ <a href="#">Specialist coinsurance</a>   | 45%            |
| ■ Hospital (facility) <a href="#">coinsurance</a>  | 45%             | ■ Hospital (facility) <a href="#">coinsurance</a>  | 45%            | ■ Hospital (facility) <a href="#">coinsurance</a>  | 45%            |
| ■ Other <a href="#">coinsurance</a>  | 45%             | ■ Other <a href="#">coinsurance</a>  | 45%            | ■ Other <a href="#">coinsurance</a>  | 45%            |
| <p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)<br/>                     Childbirth/Delivery Professional Services<br/>                     Childbirth/Delivery Facility Services<br/> <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)<br/> <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p> |                 | <p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)<br/> <a href="#">Diagnostic tests</a> (<i>blood work</i>)<br/> <a href="#">Prescription drugs</a><br/> <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p> |                | <p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)<br/> <a href="#">Diagnostic test</a> (<i>x-ray</i>)<br/> <a href="#">Durable medical equipment</a> (<i>crutches</i>)<br/> <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p> |                |
| <b>Total Example Cost</b>  | <b>\$12,800</b> | <b>Total Example Cost</b>  | <b>\$7,400</b> | <b>Total Example Cost</b>  | <b>\$1,900</b> |
| In this example, Peg would pay:  |                 | In this example, Joe would pay:  |                | In this example, Mia would pay:  |                |
| <a href="#">Cost Sharing</a>   |                 | <a href="#">Cost Sharing</a>   |                | <a href="#">Cost Sharing</a>   |                |
| <a href="#">Deductibles</a>  | \$1,900         | <a href="#">Deductibles</a>  | \$4,200        | <a href="#">Deductibles</a>  | \$1,100        |
| <a href="#">Copayments</a>   | \$0             | <a href="#">Copayments</a>   | \$0            | <a href="#">Copayments</a>   | \$0            |
| <a href="#">Coinsurance</a>  | \$4,900         | <a href="#">Coinsurance</a>  | \$2,500        | <a href="#">Coinsurance</a>  | \$900          |
| <i>What isn't covered</i>  |                 | <i>What isn't covered</i>  |                | <i>What isn't covered</i>  |                |
| Limits or exclusions   | \$60            | Limits or exclusions   | \$60           | Limits or exclusions   | \$0            |
| <b>The total Peg would pay is</b>  | <b>\$6,860</b>  | <b>The total Joe would pay is</b>  | <b>\$6,760</b> | <b>The total Mia would pay is</b>  | <b>\$2,000</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 383-7248

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 383-7248 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 383-7248.

**Armenian (հայերեն):** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 383-7248:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè bɛ́ bédjé b́á céè-djè nìà kɛ dyí ní, ɔ̀ m̀d̀ nì dyí-bédjèin-djè bɛ́ m̀ kɛ gbo-kpá-kpá kè b̄́ kp̄́ djé m̀ b́ídjí-wùdùún b́ó pídyi. Bɛ́ m̀ kɛ wuɖu-zìin-nyò djò gbo wùdù kɛ, djá (855) 383-7248.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 383-7248 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 383-7248 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 383-7248。

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## Language Access Services:

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